Patient Information Packet

Today's Date: ______________________

PATIENT INFORMATION:

Name:(Last, First MI) _______________________________________ **Preferred Name**: _______________

Address: ___________________________ **City**: _________________ **State: _________** **Zip**: ___________

Home: _________________________ **Mobile:** ___________________ **Work: _______________________**

May we text appointment reminders? ______Yes ______No

May we send you emails on events and special promotions? ______Yes ______ No **Email:** __________________________

Date of Birth:__________________________ **Gender:** M / F

***Referred By**: _____________________________________

Have you had Acupuncture before _____YES ____NO

Have you ever had a Chiropractic Service before ____YES ____NO

EMERGENCY CONTACT INFORMATION

Full Name: ____

Home:_______________________ Mobile: _____________________________

Relationship: Child / Parent / Spouse / Other:

____

FINANCIAL INFORMATION:

(a) Insurance **(b)** Worker's Comp **(c)** Self-Pay (Cash) **(d)** Personal Injury/Auto **(e)** Other________________ (please explain)

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications:

Allergies to Medications: NONE (List)____

____

____

Current Medications: NONE (Already have a list? We can make a copy.)

____

____

Major Injuries/Traumas: NONE ____

Diagnosed Medical Conditions: None____

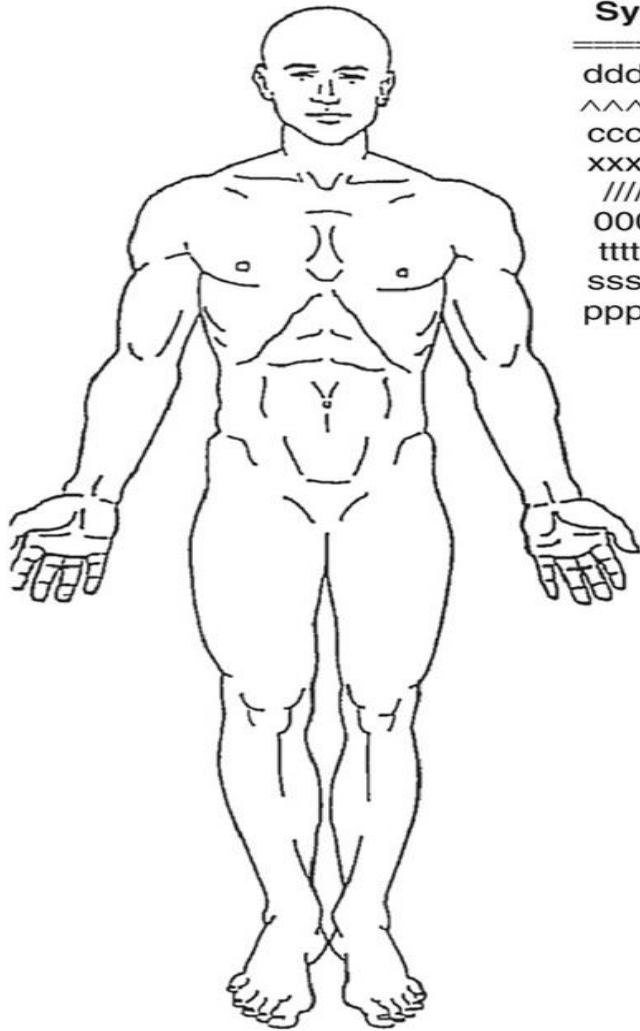
Patient Case History

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ____

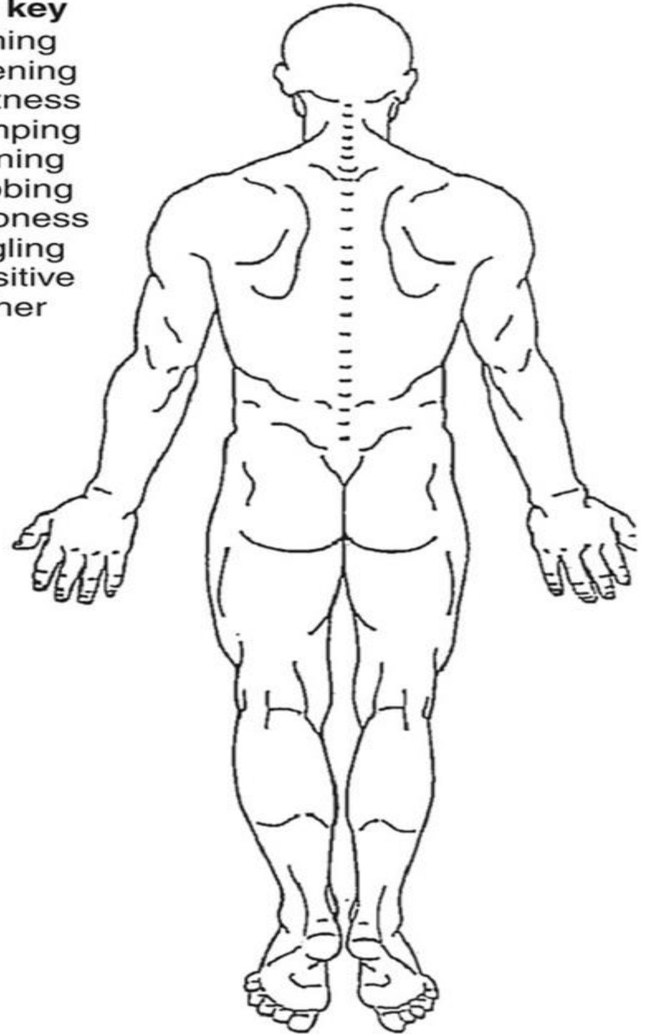
Began When?_____ /_____ /______ **Describe how this began:** ____
____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe



Symptom key

=====	Aching
dddd	Stiffening
^^^^	Tightness
cccc	Cramping
xxxx	Burning
////	Stabbing
000	Numbness
ttttt	Tingling
ssss	Sensitive
pppp	Other



<u>**For this CURRENT condition, have you:**</u>

Received any other treatment? None / DC / MD / PT / Massage / ER / Other:__________ Where?________________

Had any previous Surgery or Interventions in this area? (Describe)_____________________________________

Taken any Medications? OTC / Prescriptions **Had any diagnostic testing?** X-rays / MRI / CT / Other:

When_______________ and Where?_________________

Informed Consent for Chiropractic &/or Acupuncture Treatment:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by Wellness Concepts Clinic and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. In the practice of acupuncture there are some risks to treatment, including but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, and stuck or bent needles. Acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature: (parent if minor) _______________________________________ **Date:** ______________

Print Name:____

HIPAA Notice:

I understand and agree to allow Wellness Concepts Clinic to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules. You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

_________________________________	____
Patient Signature	Authorized provider representative
___________________________________	____
Personal representative Printed	Personal representative signature

WELLNESS CONCEPTS CLINIC
SPRINGFIELD, MO
417-877-1300

Financial Policy

Office Financial Policy and Authorization to Bill Insurance

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you chose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_______ **Private Self Pay** (you will responsible for payment of all services at the time of service)
Private Pay patients are patients that do not bill insurance. This discounted cash rate is only applied to the published rate if you pay at the time of service.

_______ **Insurance Billing** (Medical or Auto Insurance)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check out for today's visit, and every visit hereafter. Wellness Concepts Clinic will submit my claim for me to my insurance company. Although Wellness Concepts Clinic verifies my insurance; I understand that this verification is not a guarantee of payment. I understand that all charges incurred at this office including co-payment, co-insurance, percentage sure and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. **I understand Wellness Concepts Clinic charges a $5.00 processing fee per insurance claim filed, that is due at the time of service. The filing fees are charged regardless if claim is denied or claim applies towards deductible. If payment is processed for claim the $5.00 processing fee will be deducted from my insurance reimbursement.** I further understand that any unpaid balance over 90 days can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Wellness Concepts Clinic. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time, no other records shall be released without my consent.

_______________________________ Signature of Responsible Party

_______________________ Date

_______________________________ Print Name:

_______________________________ Signature of Person Authorized to Consent

_______________________ Date

_______________________________ Print Name: